Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

JOSE L DIAZ-PAGAN MD
8230 GATEWAY EAST BLVD
EL PASO TX 79907

DWC Claim #: 10340036
Injured Employee: JOSE A DIAZ
Date of Injury: 05/13/10
Employer Name: VALLEYCREST CO
Insurance Carrier #: C494C1532575

Respondent Name:
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number:
M4-12-0885-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "DWC RULE 134.600"

Amount in Dispute: $5,597.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains its denial of services provided by the requestor based on extent of injury. The Contested Case Hearing Decision and Order, as rendered by Hearing Office Teresa G. Hartley, confirms the carrier's dispute, which limited the claimant's 05/13/2010 injured to a sprain of the left knee and a strain of the lumbar spine."."

Response Submitted by: ESIS WC, PO Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2010	CPT Codes 29880, 29888, 29875, 29879	$5,597.38	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were denied by the respondent with the following reason code:

   Explanation of benefits dated November 3, 2010:

   - 1 – (219) – Based on extent of injury.

Issues

1. Did the requestor submit workers' compensation medical bills for reconsideration?
2. Is the insurance carrier's denial reason supported?

Findings

1. 28 Texas Administrative Code §133.250(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is September 14, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on November 16, 2011. This date is later than one year after the date(s) of service in dispute. Further review of the submitted documentation finds that the disputed services involve issues identified in §133.307(c)(1)(B) which states, in pertinent part, that "A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." Review of the submitted documentation finds that a contested case hearing was held to address issues of compensability, extent of injury, or liability and a final decision on the matter was issued on April 26, 2011. The request for medical fee dispute resolution was filed later than 60 days after the date the requestor received the final decision on compensability, extent of injury, or liability. The Division therefore concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

2. The insurance carrier denied disputed services with reason code 1 – "(219) – Based on extent of injury." As stated above, a contested case hearing was held to address issues of compensability, extent of injury, or liability and a final decision on the matter was issued on April 26, 2011, which held, in pertinent part, that "The compensable injury sustained on May 13, 2010 does not extend to and include MRI findings of the right knee taken on July &, 2010 (tri-compartmental osteoarthritis

with patellar and medial compartment chondromalacia, an ACL tear, peripheral tears of the medial and lateral menisci and/or a posterior horn medial meniscal tear of the left knee)…" Review of the submitted documentation finds that the requestor performed arthroscopic knee surgery. The Division concludes that the disputed services were not rendered in treatment of the injured worker's compensable injury. The respondent's denial reasons are supported. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Marguerite Foster	December 19, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.